Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - November is American Diabetes Month® ~ The American Diabetes Association has designated American Diabetes Month® as a time to communicate the seriousness of diabetes and the importance of proper diabetes control. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. Medicare also provides coverage for services to help beneficiaries effectively manage their diabetes. Coverage of these services is subject to certain eligibility and other limitations. For more information about Medicare's coverage of diabetes screening services, diabetes self-management training, and medical nutrition therapy services, including coverage, coding, billing, and reimbursement guidelines, visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products web page at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS website.

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2008 Physician Quality Reporting Initiative Claims-Based Reporting of Measures Groups

Provider Types Affected

Physicians and practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI).

What You Need to Know

CR 6187, from which this article is taken, announces that the 2008 PQRI Claims-Based Measures Groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008. If you successfully report under this method; you may, on that basis, receive an incentive payment equal to 1.5 percent of the total allowed Medicare Physician Fee Schedule (MPFS) charges for covered professionals during this period.

Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized CMS to establish alternative methods to report 2008 Physician Quality Reporting Initiative (PQRI) quality data, including the option of reporting on a group of clinically-related measures. Four Measures Groups have been established for 2008 PQRI: 1) Diabetes Mellitus, 2) End Stage Renal Disease (ESRD), 3) Chronic Kidney Disease (CKD), and 4) Preventive Care. These four groups, which combined include a total of 22 measures, may be reported through either claims-based or registry-based submission.

CR 6187, from which this article is taken, announces that the 2008 PQRI Claims-Based Measures Groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008.

You may choose to report through more than one 2008 PQRI reporting option. Professionals, who successfully report under more than one reporting option, will receive a maximum of one incentive payment, which will be equivalent to 1.5% of MPFS allowed charges for all covered professional services that you furnish to patients enrolled in Medicare Part B Fee-For-Service during the July through December, 2008 reporting period..

Note: Medicare Part C (e.g., Medicare Advantage) claims will not be utilized for 2008 PQRI analysis.

In order to identify your intent to report a measures group, you should submit a measures group-specific G-code on a claim for covered professional services furnished to a patient enrolled in Medicare Part B Fee-For-Service:

G8485: I intend to report the Diabetes measure grouping;

G8488: I intend to report the End Stage Renal Disease (ESRD) measure grouping;

G8487: I intend to report the Chronic Kidney Disease (CKD) measure grouping;

G8486: I intend to report the Preventive Care measure grouping.

You do not need to submit the measures group-specific G-code on more than one claim. In fact, if you submit the G-code for a given group multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analyses; and subsequent submissions of that code will be ignored.

Remember that there are two reporting methods for claims-based submission of measures groups:

- Consecutive Patient Sample Method: You must report on all applicable measures within the selected measures group on claims for 15 consecutive Medicare Part B Fee-For-Service patients who meet patient sample criteria for the measures group, beginning with the first date of service for which the measures group-specific G-code is submitted. For example, you can indicate intent to begin reporting the Diabetes Mellitus Measures Group by submitting G8485 on the first patient claim in the series of

consecutive diabetic patients. You must report all the applicable measures within the group at least once for each patient within the sample population seen during the reporting period.

OR

- 80% Patient Sample Method: You must report on all applicable measures within the selected measures group on claims for at least 80% of all Medicare Part B Fee-For-Service patients seen during the entire reporting period (July 1 – December 31, 2008) who meet the measures group patient sample criteria. For this method, you must submit the measures group-specific G-code once during the reporting period to indicate your selection of the measures group. You must report all applicable measures within the group at least once for each patient within the sample population seen during the reporting period.

The patient samples for both the Consecutive Patient Sample Method and the 80% Patient Sample Method are determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. You must report all applicable measures within a group for each patient within the sample that meets the criteria (age, gender, or additional diagnosis) required in accordance with the 2008 Physician Quality Reporting Initiative Claims-Based Measures Groups Handbook located at *http://www.cms.hhs.gov/PQRI/01_Overview.asp* as a downloadable file under the PQRI Tool Kit link.

For example, if you are reporting on the Preventive Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on women within the patient sample. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group.

CR 6187 also includes a step-by-step strategy (including clinical examples) to facilitate your successful reporting through this claims-based reporting alternative (for completeness, some of the above information is repeated in this strategy section).

Additional Information

You can find more information about using the Claims-Based Reporting of Measures Groups option for reporting 2008 PQRI data by going to CR 6187, located at *http://www.cms.hhs.gov/Transmittals/downloads/R401OTN.pdf* on the CMS website.

You might also want to review MLN Matters article MM6104, *2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria*, released on June 13, 2008 to learn more about the 2008 PQRI Program. You can find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6104.pdf* on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

You might find it of value to circulate the following portion of this article to your office staffs.

Measures Groups Participation Strategy

- Plan and implement processes within your practice to ensure successful reporting of measures groups.
- Determine your patient sample based on the patient sample criteria, which is used for both the Consecutive Patient Sample Method and the 80% Patient Sample Method. The following table contains patient sample criteria (common codes) that will qualify a Medicare Part B patient's professional services claim for inclusion in the measures group analysis. Claims must contain a specific line-item ICD-9 diagnosis code (where applicable) accompanied by a specific CPT patient encounter code.

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9 Diagnosis Codes
Diabetes Mellitus *18–75 years*	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04
End Stage Renal Disease (ESRD) *18 years and older*	90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319	585.6
Chronic Kidney Disease (CKD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	585.4, 585.5
Preventive Care 50 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	

- Indicate your intention to begin reporting a measures group by submitting a measures group-specific G-code (G8485. G8488, G8487, or G8486) as noted above.
- Measures group-specific G-code line items on the claim must be complete, including accurate coding, date of service and diagnosis pointer. The diagnosis pointer field on the claim links one or more patient diagnoses to the service line. A G-code specific to a condition-specific measures group (*e.g.* Diabetes Mellitus Measures Group) should be linked to the diagnosis for the condition to which it pertains; a G-code for the Preventive Care Measures Group may be linked to any diagnosis on the claim.
- Measures group-specific G-code line items should be submitted with a charge of zero dollars ($0.00). Measures group-specific G-code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. You should check your Remittance Advice ("Explanation of Benefits" or "EOB") for a denial code (e.g., N365) for the measures-group-specific G-code, confirming that the code passed through your local carrier to the National Claims History file. The N365 denial indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of measures group-specific G-codes.
- For patients for who measures groups apply, report all applicable individual measures for the measure group. Report quality-data codes (QDCs) as instructed in the *2008 PQRI Claims-Based Measures Groups Handbook* located at http://www.cms.hhs.gov/PQRI/01_Overview.asp on all applicable measures within the measures group for each patient included in the sample population. You may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used when calculating reporting and performance rates for each measure within a group. You are only required to report QDCs on those individual measures in the measures group that meet the criteria (age, gender, or additional diagnosis) according to the *2008 PQRI Measures Groups Handbook*. For example, if you are reporting the Preventive Care Measures Group for a 52 year old female patient, only five measures out of nine apply. See the following Preventive Measures Group Demographic Criteria table:

Preventive Measures Group Demographic Criteria		
Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis

50-64 years	110, 113, 114, 115	110, 112, 113, 114, 115
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
≥81 years	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

Another example would be: if you are reporting on the CKD Measures Group, you would not be expected to report measure 120 *(ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD)* for a CKD patient who does not also have hypertension and proteinuria.

There are two types of patients that can be reported in the ESRD measures group; those that have ESRD and are undergoing hemodialysis, and those that have ESRD and are undergoing peritoneal dialysis. If you choose to report this measures group you should report the appropriate quality-data code for all four measures if the patient is receiving hemodialysis. However, if the patient is receiving peritoneal dialysis, only measures #79 and #80 should be reported as these two measures do not apply to patients undergoing peritoneal dialysis.

Reporting Measures Groups - Common Clinical Scenarios:

The following clinical scenarios are offered as examples describing the quality data that should be reported on claims using a measures group's method:

Diabetes Mellitus Example

Primary care office visit for a new patient with newly diagnosed diabetes mellitus: A1c = lab drawn, result unknown, prior result not available (3046F-8P); LDL-C=110 (3049F); today's BP = 140/80 (3077F, 3079F); referred to ophthalmologist for dilated eye exam (2022F-8P); urine protein screening performed = negative (3061F)

Dx 1: 250.00

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99201		1	$60.00	0123456789
	07/01/2008	G8485		1	$0.00	0123456789
	07/01/2008	83036		1	$15.00	0123456789
	07/01/2008	81000		1	$6.00	0123456789
1	07/01/2008	3046F	8P	1	$0.00	0123456789
2	07/01/2008	3049F		1	$0.00	0123456789

3	07/01/2008	3077F		1	$0.00	0123456789
3	07/01/2008	3079F		1	$0.00	0123456789
117	07/01/2008	2022F	8P	1	$0.00	0123456789
119	07/01/2008	3061F		1	$0.00	0123456789

The above is an example of successful reporting in PQRI. In this example, the eligible professional has chosen to report measures 1 and 117 with an 8P modifier indicating that performance of the measure was not met on this visit. An eligible professional may choose whether to report these two measures on the current claim or wait to report them on a claim for a subsequent visit during the reporting period after the results of the test/exam are available.

ESRD Example

Hemodialysis visit for a patient with ESRD: AV Fistula = functioning (4052F); documentation of flu vaccination received on January 1, 2008 (4037F); Hgb = 10 with a plan of care documented (3281F, 0516F); Ktv = 1.3 (3083F)

Dx 1: 585.6

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	90935		1	$500.00	0123456789
	07/01/2008	G8488		1	$0.00	0123456789
78	07/01/2008	4052F		1	$0.00	0123456789
79	07/01/2008	4037F		1	$0.00	0123456789
80	07/01/2008	3281F		1	$0.00	0123456789
80	07/01/2008	0516F		1	$0.00	0123456789
81	07/01/2008	3083F		1	$0.00	0123456789

CKD Example

Stage 5 CKD patient, not receiving RRT, office visit: known hypertensive with documented plan of care for hypertension (G8477, 0513F); urinalysis indicates proteinuria, documentation of current prescription for ACE inhibitor (G8479); lab tests ordered on last visit and results documented in the chart (3278F); Hgb = 14 and patient is receiving ESA and has a plan of care documented for elevated hemoglobin level (3279F, 0514F, 4171F)

Dx 1: 585.5; Dx 2: 401.0; Dx 3: 791.0

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99213		1	$50.00	0123456789
	07/01/2008	G8487		1	$0.00	0123456789
120	07/01/2008	G8479		1	$0.00	0123456789
121	07/01/2008	3278F		1	$0.00	0123456789
122	07/01/2008	G8477		1	$0.00	0123456789

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
122	07/01/2008	0513F		1	$0.00	0123456789
123	07/01/2008	3279F		1	$0.00	0123456789
123	07/01/2008	0514F		1	$0.00	0123456789
123	07/01/2008	4171F		1	$0.00	0123456789

Preventive Care Example

Primary care office visit for a 67 year old female, established patient. Presents with mild cold symptoms. Record indicates patient had a DXA done at age 62, with results documented as within normal limits (G8399); denies urinary incontinence (1090F); record indicates influenza vaccination at a previous visit in January of this year (G8482); pneumonia vaccination administered last year (4040F); results of last month's mammogram (3014F) and last week's FOBT (3017F) reviewed with patient; denies tobacco use (1000F, 1036F, G8457); today's BMI measurement = 24 (G8420)

Dx 1: Use any visit-specific diagnosis for the measures in this group

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99212		1	$45.00	0123456789
	07/01/2008	G8486		1	$0.00	0123456789
39	07/01/2008	G8399		1	$0.00	0123456789
48	07/01/2008	1090F		1	$0.00	0123456789
110	07/01/2008	G8482		1	$0.00	0123456789
111	07/01/2008	4040F		1	$0.00	0123456789
112	07/01/2008	3014F		1	$0.00	0123456789
113	07/01/2008	3017F		1	$0.00	0123456789
114	07/01/2008	1000F		1	$0.00	0123456789
114	07/01/2008	1036F		1	$0.00	0123456789
115	07/01/2008	G8457		1	$0.00	0123456789
128	07/01/2008	G8420		1	$0.00	0123456789